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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 3447

Registration District No. 7

Primary Registration District No. 3040

Registrar's No. 8

1. PLACE OF DEATH:

(a) County: Livingston

(b) City or town: Chillicothe
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution: 56 Washington Street 1
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)

In this community: 50 years

2. USUAL RESIDENCE OF DECEASED:

(a) State: Missouri (b) County: Livingston 1

(c) City or town: Chillicothe 9
(If outside city or town limits, write "RURAL")

(d) Street No.: 56 Washington Street
(If rural, give location)

(e) Citizen of foreign country? No (Yes or No)

If yes, name country: 0

3. (a) PRINT FULL NAME: John Francis Cooney

3. (b) If veteran, name war: No

3. (c) Social Security No.: None

4. Sex: Male

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife:

6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased: Oct. (Month) 22 (Day) 1872 (Year)

8. AGE: Years 71 | Months 2 | Days 25 | If less than one day ..... hr. ..... min.

9. Birthplace: Cincinnati (City, town, or county) Ohio 1 (State or foreign country)

10. Usual occupation: Constable

11. Industry or business:

FATHER
12. Name: Unknown
13. Birthplace: " (City, town, or county) 9 (State or foreign country)

MOTHER
14. Maiden name:
15. Birthplace: Unknown (City, town, or county) 9 (State or foreign country)

16. (a) Informant: Mrs Howadr Danial

(b) Address: Chillicothe, Missouri.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 1-20-'44 (Month) (Day) (Year)

(c) Place: burial or cremation: Edgewood Cemetery

18. (a) Signature of funeral director: F. B. Norman Co.

(b) Address: Chillicothe, Missouri.

19. (a) JAN 19 (Date received local registrar) (b) Lou Ella Conry (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan. day 17th. year 1944 hour 8:00 minute A. M.

21. I hereby certify that I attended the deceased from April 5, 1942 to Jan 17, 1944 that I last saw him alive on Jan 17, 1944 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Cerebral hemorrhage	1 hr
Due to: Arterio-sclerosis	2 yrs
Due to:	
Other conditions (Include pregnancy within 3 months of death):	
Major findings: Of operations: 8 3a 1	
Of autopsy:	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify):

(b) Date of occurrence:

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)

While at work?

(e) Means of injury:

23. Signature: H. M. Russell M.D. (M.D. or other)

Address: Chillicothe Mo. Date signed: 1/18/44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N 8 (Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by E. R. Norman, Registered Apprentice No. _____, working under my personal supervision.

Signed E R Norman

Licensed Embalmer No. 2374

P. O. Address Chillicothe, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.